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Hospital Community Benefits after the ACA: Policy Implications of the State Law Landscape

Gayle D. Nelson, Martha H. Somerville, Carl H. Mueller, Cynthia L. Boddie-Willis

Introduction

The Community Benefit State Law Profiles (Profiles), launched in March 2013 by The Hilltop Institute's Hospital Community Benefit Program, are an open-access online resource for understanding each state's community benefit framework, as defined by state law, regulation, and, occasionally, the policies and actions of state executive agencies.¹ Each state's profile is framed in terms of the community benefit provisions of §9007 of the Affordable Care Act (ACA)² and §501(r) of the Internal Revenue Code (IRC). The Profiles also identify tax exemptions available to nonprofit hospitals in most states and link directly to each statute, regulation, or other online reference. The Profiles can be accessed at http://www.hilltopinstitute.org/hcbp_cbl.cfm.

The first companion brief to the Profiles, *Hospital Community Benefits after the ACA: The State Law Landscape*, described state community benefit requirements organized into eight categories, largely reflecting pre-existing community benefit

standards and the additional requirements set forth in ACA §9007:

- Community benefit requirement
- Minimum community benefit requirement
- Community benefit reporting requirement
- Community health needs assessment
- Community benefit plan/implementation strategy
- Financial assistance policy
- Financial assistance policy dissemination
- Limitations on charges, billing, and collections

This second companion brief explores select policy issues raised by an analysis of the data in the Profiles.

As state policymakers, nonprofit hospitals, and community stakeholders assess their states'

Gayle D. Nelson, JD, MPH, is a Policy Analyst at The Hilltop Institute at UMBC. Martha H. Somerville, JD, MPH, is a Senior Policy Analyst at The Hilltop Institute at UMBC and directs Hilltop's Hospital Community Benefit Program. Carl H. Mueller, MS, is a Policy Analyst at The Hilltop Institute at UMBC. Cynthia L. Boddie-Willis, MD, MPH, is Director of Health Services Policy and Research at The Hilltop Institute at UMBC.

community benefit environments in the wake of national health reform, the Profiles and the two associated issue briefs provide a context for con-

sidering each state's policies in light of federal community benefit benchmarks and the requirements of other states.

The Federal Framework

The federal government's expectations for nonprofit hospitals that seek federal tax exemption for charitable activities have evolved over time. In 1969 the Internal Revenue Service (IRS) replaced an earlier standard that had focused solely on the "financial ability" of tax-exempt nonprofit hospitals to provide charity care and low-cost medical services. At that time, the IRS adopted a broader standard for tax exemption, termed the "community benefit" standard, based on the extent to which nonprofit hospitals provide benefits to the neighborhoods and populations they serve (Rev. Rul. 69-545).

The federal government's interpretation of the community benefit standard remained essentially unchanged until 2007, when the IRS redesigned Form 990, an informational tax return that tax-exempt hospitals are required to file. At that time, the IRS introduced a new Schedule H to augment the financial data collected from nonprofit hospitals (Davis, 2011). The purpose of the new schedule was to increase transparency and objectively categorize nonprofit hospitals' community benefit activities (IRS, 2007; Somerville, Nelson, Mueller, Boddie-Willis, & Folkemer, 2013). Part I of the 2012 Schedule H, "Financial Assistance and Certain Other Community Benefits at Cost," delineates broad categories of community benefit activities that justify federal tax exemption (IRS, n.d.a.). Those categories are: financial assistance (free and discounted care); unreimbursed costs of Medicaid and other means-tested government programs; community health improvement services and community benefit operations; health professions education; subsidized health services; research; and cash and-in-kind contributions

(IRS, n.d.a.; Rosenbaum, Byrnes, & Rieke, 2013).

In 2010, ACA §9007 instituted additional federal requirements that nonprofit hospitals must meet to establish or maintain eligibility for federal tax exemption. These new standards include (I.R.C. §501(r) (3)-(r)(6)):

- Conducting a community health needs assessment (CHNA) every three years
- Developing an implementation strategy to meet the needs identified in the CHNA
- Adopting and disseminating written policies on financial assistance and emergency care
- Limiting charges, billing, and collections with respect to individuals eligible for financial assistance under a nonprofit hospital's financial assistance policy

More recently, the IRS issued two sets of proposed federal rules (Notice of Proposed Rule-making [NPRM]) that, if implemented, could impact state community benefit requirements. The first set of proposed rules would implement the ACA's provisions on financial assistance policies, limitations on nonprofit hospital charges, and billing and collection requirements (IRS, 2012). The period for public comment on those proposed rules ended September 24, 2012. The second set of proposed rules adds to and modifies the agency's earlier guidance on community health needs assessment and implementation strategies, Notice 2011-52 (IRS, 2013a). The public comment period for the 2013 NPRM ended July 5, 2013.³

To date, neither federal law nor IRS guidance either 1) quantifies the specific amount of community benefits to be provided; or 2) furnishes a detailed description of community benefit activities that nonprofit hospitals must provide in order to qualify for or maintain their tax exempt status (Rev. Rul. 69-545; IRS, n.d.b., 2013a, 2012). Many state governments, which separately confer property, income, and sales tax exemptions, have made individualized determinations regarding

state-level community benefit obligations for nonprofit hospitals within their jurisdictions. As a consequence, nonprofit hospitals located in these states must satisfy both federal and state community benefit requirements. States that find their standards to be inconsistent with federal requirements may choose to reassess their community benefit regulatory schemes against the new federal landscape.

Overview of This Brief

This brief describes state community benefit requirements organized into eight categories that largely reflect either pre-existing federal community benefit standards or additional requirements set forth in ACA §9007. Some states will be shown to have existing requirements for a given category that fully align with federal standards. Others will have no corresponding state requirement; hence, they will comply with federal standards by default. Policymakers in states that fall into one of these two groups will not need to take action to comply with federal directives.

The absence of a state requirement may reflect any number of determinations by state policymakers, including 1) that no state standards are needed; 2) that state standards are needed, but

state interests are satisfied by adherence to federal standards; or 3) that state standards are needed, but the ensuing burden imposed on nonprofit hospitals and state regulators may outweigh the benefits of establishing additional state requirements.

States are not required to defer to federal tax exemption standards and may choose to establish their own standards for nonprofit hospitals. The following discussion primarily focuses on instances in which state and federal requirements both coexist and differ from one another, highlighting key issues that policymakers may wish to consider as they assess their states' regulatory schemes against the broad and evolving federal landscape.

Community Benefit Requirement

To be eligible for tax exemption under the “community benefit standard,” nonprofit hospitals are required to provide hospital-subsidized benefits to the neighborhoods and populations they serve (Rev. Rul. 69-545; Somerville, Nelson, & Mueller, 2013).

Twenty-three states separately require nonprofit hospitals to provide community benefits on either a conditional or unconditional basis.⁴ In those states, laws specifically directed toward nonprofit hospitals generally relate to the nature of the ben-

efits they provide to their communities,⁵ their contributions to improving health care access and community health status,⁶ and the fairness of their business practices.⁷

Some states, including California, refer to these charitable expectations as “community benefits” (Cal. Health & Safety Code §127340(a)). Others use different terms. Illinois, for example, requires nonprofit hospitals to provide charity care and “health services to low income or underserved individuals” (35 ILCS 200/15-86(e)(2)). Alt-

though state charitable expectations vary significantly in scope and detail from one jurisdiction to another, states generally contemplate, at a minimum, that nonprofit hospitals will provide charity (free) and discounted care, and that they will absorb shortfalls from Medicaid and other means-tested government health care programs (GAO, 2008).

The existence of state community benefit requirements can have important policy implications. If, for example, a state wishes to incentivize nonprofit hospitals to direct greater portions of their community benefit investments toward “community building,”⁸ (i.e., activities subsidized by a nonprofit hospital that benefit community health but do not involve the provision of medical care), the state could adopt a definition of “community benefit” that expressly includes community-building activities. That state’s nonprofit hospitals would then be able to both comply with state community benefit requirements and advance state policy goals by directing their community benefit investments toward community-building activities. California and Maryland, for example, both consider “community-building” activities to be community benefit for the purpose of meeting state community benefit standards (Somerville, Nelson, & Mueller, 2013). The fiscal year (FY) 2012 Maryland Hospital Community Benefits Report outlines Maryland nonprofit hospitals’ aggregate net community-building expenditures of \$23,244,560 in the following categories: Physical Improvements/Housing, Economic Development, Support System Enhancements, Environmental Improvements, Leadership Development/Training for Community Members, Coalition Building, Community Health Improvement Advocacy, and Workforce Enhancement (Health Services Cost Review Commission, 2013).

Minnesota provides an example of a legislative attempt to advance state-specific objectives using

community benefit requirements. Although tax-exempt hospitals were required to satisfy the broad federal community benefit requirement, Minnesota law did not expressly require nonprofit hospitals to provide community benefits.⁹ Faced with a challenging fiscal climate in 2011, the Minnesota legislature approved budget language that would have required its nonprofit hospitals to align their community benefit investments with the goals and priorities of the State Health Improvement Plan (SHIP): reducing obesity and tobacco use. The Minnesota Health Department convened a series of “town hall collaboration meetings” and the Minnesota Hospital Association, a key stakeholder, opposed granting the state health department authority to “review or approve” nonprofit hospital community benefit plans based on their alignment with SHIP priorities. The hospital association emphasized, among other points, that the state review process would duplicate federal needs assessment and reporting requirements under the ACA (Minnesota Hospital Association, 2012). In April 2012, budget provisions requiring alignment of nonprofit hospital community benefit plans with SHIP priorities were repealed (The Hilltop Institute, 2012).

One insight to be drawn from the Minnesota experience is that establishing community benefit requirements for the first time can be challenging. State policymakers may wish to consider and carefully balance such factors as 1) the traditionally autonomous roles of nonprofit hospitals in assessing the health needs of their particular communities; 2) new ACA requirements; 3) statewide health status; 4) state goals to be advanced; 5) input from state and local public health agencies; and 6) input from stakeholders.

Minimum Community Benefit Threshold

Although Schedule H requires nonprofit hospitals to disclose their net community benefit investments, federal law (including the ACA) does not specify a minimum threshold level of community benefit to be provided by tax-exempt hospitals. The IRS employs a “facts and circumstances” test¹⁰ that takes into consideration all relevant circumstances in making its determination as to whether or not a hospital’s community benefit contributions are sufficient to support federal tax exemption (IRS, 2010).

Similarly, 45 states do not require the provision of specified levels of community benefit. However, five states—Illinois, Nevada, Pennsylvania, Texas, and Utah—do specify minimum community benefit thresholds. Nevada provides an example of a straightforward minimum community benefit threshold, with a law that requires both nonprofit and for-profit hospitals to provide care for indigent inpatients in an amount that represents at least 0.6 percent of the hospitals’ net revenue¹¹ (Nev. Rev. Stat. §439B.320).

The Illinois minimum community benefit threshold, enacted in 2012, requires nonprofit hospitals that seek property tax exemption to provide charity care or other “health services to low-income or underserved individuals” at levels at least equivalent to what the hospital would otherwise be required to pay in property taxes (35 ILCS 200/15-86(c)). In enacting this statute in the wake of *Provena Covenant Medical Center v. Department of Revenue*, the Illinois legislature expressly stated its intention to resolve [the] “considerable uncertainty surrounding the test for charitable property tax exemption, especially regarding the application of a quantitative or monetary threshold,” which the Illinois Supreme Court had expressed in *Provena* (35 ILCS 200/15-86(a)); The Hilltop Institute, 2011).¹²

Details of the minimum community benefit requirements of Pennsylvania,¹³ Utah, and Texas are contained in their Profiles.

There are a variety of viewpoints concerning whether minimum community benefit thresholds are the optimal way to assess the benefits that nonprofit hospitals provide to the neighborhoods and populations they serve. In 2007, the Minority staff of the U.S. Senate Finance Committee supported the concept of minimum thresholds and prepared a draft proposal requiring each nonprofit hospital to dedicate “a minimum of 5% of its annual patient operating expenses or revenues to charity care, whichever is greater” (Miller, 2009).

Recent studies of 2009 Schedule H data determined that aggregate hospital community benefit expenditures amount to an average of 7.5 percent of hospital operating expenditures nationally (Young , Chou, Alexander, Lee, & Raver, 2013) and in Wisconsin (Bakken & Kindig, 2012).¹⁴ The 2009 Schedule H data for California showed that aggregate community benefit expenditures accounted for 11.5 percent of hospitals’ total operating expenses. The substantially higher figure was attributed to high levels of uninsurance and low Medi-Cal reimbursement rates (Singh, 2013). Interestingly, these reported rates all exceed 5 percent, even though California, Wisconsin, and 43 other states do not have mandatory minimum thresholds.

There is some evidence that implementing minimum community benefit thresholds may not result in increased community benefit investments. Texas has a requirement that nonprofit hospitals spend a minimum of 4 percent of their net patient revenue on charity care. After the law took effect in 1993, nonprofit hospitals that were previously spending below the 4 percent threshold increased

their charity care spending. However, nonprofit hospitals that were previously spending above the threshold actually *decreased* their charity care spending somewhat. Overall, researchers concluded that the Texas law changes did not generally lead to increased charity care spending by Texas nonprofit hospitals (Kennedy, Burney, Troyer, & Stroup, 2010).

In its adoption of Schedule H, the IRS seems to prefer consistent measurement and reporting of nonprofit hospital community benefit expenditures (i.e., better data rather than mandatory minimum thresholds) (Miller, 2009). One argument advanced in favor of setting minimum community benefit thresholds is that such an approach is a straightforward way of establishing a “floor” and is easier to audit and administer (*Attorney General’s Task Force Final Report, 1989*).

Community Benefit Reporting

Schedule H clearly delineates the categories of reportable, unreimbursed community benefit expenditures that must be reported. These federally established categories apply to all nonprofit hospital facilities seeking federal tax exemption.¹⁵ Detailed reporting requirements such as those on Schedule H and mandated by several states would seem to promote accountability (Barnett & Somerville, 2012; IRS, 2007) and allow policymakers flexibility in evaluating and comparing nonprofit hospitals’ community benefit investments.

Twenty-eight states require some form of state-level reporting of community benefits,¹⁶ with most of these requirements established prior to implementation of Schedule H (Hellinger, 2009). States may adopt community benefit reporting requirements to enhance transparency, as a tool for determining a nonprofit hospital’s eligibility for tax exemption or other state-conferred preference or authorization, or for other policy-related purposes (Folkemer et al., 2011). North Carolina,

In the absence of evidence that mandatory thresholds yield a greater community benefit investment, however, some researchers—and some state and local governments—continue to evince concern about the adequacy of community benefit investments by nonprofit hospitals (Rubin, Singh, & Jacobson, 2013; Singh, 2013). Policymakers may wish to carefully consider the framework of their state’s overall community benefit landscape. As the ACA is implemented and Schedule H data become more easily available, dialogue among policymakers, nonprofit hospitals, and other stakeholders may demonstrate whether increased transparency and accountability of net community benefit investments—as opposed to mandatory thresholds—result in optimal community benefit investments.

for example, requires nonprofit hospitals to report community benefits as a condition of receiving state authorization to issue tax exempt financing (N.C. Gen. Stat. §131A-21).

Community benefit reporting laws in the states differ from federal requirements and from one another. Some states require only that nonprofit hospitals report charity care expenditures.¹⁷ Other states require more and their additional reporting requirements reflect a policy goal of the state. Maryland, for example, requires that each nonprofit hospital’s community benefit report documents the hospital’s efforts to track and reduce health disparities within its community.¹⁸ Maryland nonprofit hospitals must also report and describe any gaps in the availability of specialist providers to serve the uninsured in the community that the hospital serves. (Md. Code Ann., Health-Gen. 19-303(c)(vii)). These provisions, adopted as part of the *Maryland Health Improvement and Disparities Reduction Act of 2012*, SB 234 (Chapter 3), advance a state policy

to “reduce health disparities among Maryland racial and ethnic groups...” [and] “improve health care access and outcomes in underserved communities” (Maryland Office of Minority Health and Health Disparities, 2012).

Policymakers may wish to carefully compare the content of state-required reporting to state policy goals. In states where such reporting can be

shown to advance important state goals, policy-makers may choose to retain or perhaps even expand the state reporting requirements. Otherwise they could choose to eliminate required reporting of that information. To date, however, it does not appear that any state has eliminated reporting of data elements or otherwise reduced its reporting requirements.

Community Health Needs Assessment

ACA §9007 requires that tax-exempt hospitals conduct community health needs assessments (CHNAs) that “take into account”—at least every three years—the input of individuals who represent the broad interests of the community and who have special public health knowledge or expertise. The 2013 NPRM goes a step further by requiring, among other things, that each nonprofit hospital “must take into account” input from:

- At least one state, local, tribal, or regional governmental public health department (or equivalent) with knowledge, information, or expertise relevant to the health needs of the community (§1.501(r)-3(b)(5)(i)), and
- Members of “medically underserved, low-income, and minority populations in the community served by the hospital or individuals/organizations serving or representing the interests of such populations.” (§1.501(r)-3(b)(5)(ii))¹⁹

For purposes of this latter provision, “medically underserved populations” include populations experiencing health disparities or at risk of receiving inadequate medical care as a result of being uninsured or underinsured, or due to geographic, language, financial, or other barriers (§1.501(r)-3 (b)(6)).

Eleven states require nonprofit hospitals to conduct CHNAs.²⁰ The laws of those states vary considerably with respect to which entities should be consulted in the CHNA process. Only

Maryland mandates that nonprofit hospitals consider, if available, input from the state health department (Department of Health and Mental Hygiene) or local health departments;²¹ they may also include consultations with community leaders, local health care providers and “any appropriate [other] persons.” California and New Hampshire require that nonprofit hospitals consult with community groups and local government officials, although not necessarily with local health departments. Seven of the remaining eight²² states do not mandate—as part of the CHNA process—that nonprofit hospitals take into account input from either health departments or local government officials.²³

Texas provides a unique example in that the state requires nonprofit hospitals to “consider consulting with and seeking input from...” a detailed list of entities: 1) the local health department; 2) the public health region;²⁴ 3) the public health district;²⁵ 4) health-related organizations, including a health professional association or hospital association; 5) health science centers; 6) private business; 7) consumers; 8) local governments; and 9) insurance companies and managed care organizations with an active market presence in the community (Tex. Health and Safety Code Ann. §311.044(d)).

A state-level decision to specify a list of community groups and/or other entities to be included as part of the CHNA process presents both policy and practical implications. On one hand, identify-

ing and engaging specific groups could garner support for and promotion of state policy goals. This process, however, requires a determination of which groups should be listed. Formulating an “appropriate” list could be challenging, and stakeholders that are not listed may appear to have been negatively impacted.

In addition, legislators may wish to specify the roles of the listed entities. How are nonprofit hospitals to “take into account” their input? Is consultation with them mandatory or merely sug-

gested? Or are the views of the listed entities simply to be solicited? Further, and as a practical matter, legislators may want to determine an optimum number of listed entities, or the CHNA process could become unwieldy by virtue of sheer numbers.

State decision makers may seek to advance policies and/or ensure participation of segments of the community through the CHNA process. However, they should carefully consider the optimal ways to achieve those objectives.

Implementation Strategy/Community Benefit Plan

ACA §9007 requires that each tax-exempt hospital adopt “an implementation strategy to meet the community health needs identified through [its CHNA].” The implementation strategy is a written plan: many state laws use the term “community benefit plan” instead. This key document can be considered an action guide, setting forth the nonprofit hospital’s proposed approach for addressing significant health needs in its community (Spugnardi, 2013). Implementation strategies further the ACA’s goal of enhancing community benefit accountability because they set forth the actions that a nonprofit hospital intends to take to address each significant health need identified through the CHNA process. The reporting of implementation strategies also furthers community benefit transparency. These strategies must be made publically available via Form 990; a nonprofit hospital may either attach the implementation strategy to its Form 990 or provide on that Form 990 the URL(s) of the web page(s) where the implementation strategy has been made widely available (§1.501(r)-3(c)).

The 2013 NPRM further would require that, with respect to each significant health need identified in the CHNA, the implementation strategy must set forth, among other things (§1.501(r)-3(c)):

- Actions the nonprofit hospital plans to take to address the need or, alternatively, an explana-

tion of why the hospital does not intend to address the health need

- The anticipated impact of these actions
- A plan to evaluate the impact
- Resources and programs the nonprofit hospital plans to commit to address the identified need
- Any planned collaboration between the nonprofit hospital facilities and other facilities

The requirement that an implementation strategy contain a plan to evaluate the impact of community benefit activities is notable; the IRS had not previously required this of nonprofit hospitals.

Only ten states direct hospitals to develop community benefit plans/implementation strategies.²⁶ Eight of those states also require evaluation plans. Indiana, Massachusetts (voluntary), Texas, and Washington State require that the community benefit plan/implementation strategy contain measurable objectives or evaluation measures. Four other states (California, Connecticut, Maryland, and New Hampshire) also require the reporting of similar information. The 2013 NPRM does not specify how the impact of community benefit activities should be evaluated: it only would require that the implementation strategy contain a plan to evaluate the impact (§1.501(r)-

3(c) (2)). Typical evaluation criteria include whether intended populations were reached and whether participation goals were satisfied (Catholic Health Association, 2012).

Theoretically, it is possible to evaluate the impact of community benefit activities based on outcomes; i.e., attaining certain objectives. In fact, a small number of scholars have recently argued for or supported consideration of an outcome-based approach to nonprofit hospital tax exemption (Rubin et al., 2013; Singh, 2013). However, even those scholars acknowledge the difficulty in directly attributing population health outcomes to individual nonprofit hospitals and their community benefit initiatives (Rubin et al., 2013; Singh, 2013). Furthermore, an outcome-based approach could raise concerns regarding whether nonprofit hospitals might become risk-averse, perhaps

leading to a smaller number of creative, innovative strategies and activities.

A 2012 Washington State law, enacted prior to the 2013 NPRM, offers a novel, bifurcated approach to the subject of evaluations. This law requires that implementation strategies must be evidence-based “when available” or that innovative programs and practices must be supported by evaluation measures (2012 Wash. Laws, Ch. 103). Whether or not the IRS-proposed evaluation requirement is adopted in its present form, the Washington statute offers an innovative approach to gauging nonprofit hospital community benefit activities. However, policymakers seeking to establish state evaluation requirements may wish to consider other approaches, some of which still might be informed by the Washington approach.

Patient Financial Protections: Financial Assistance Policies (FAP)/FAP Dissemination/Limitations on Charges, Billing, and Collection Activities

Problems associated with the high cost of medical care in the United States are well documented. An illustrative example is the fact that, during the first six months of 2012, 54.2 million people under age 65 were in families having problems paying medical bills (CDC, 2013). There has been recent Congressional attention (U.S. Senate Committee on Health, Education, Labor & Pensions, 2012) and popular media coverage (Brill, 2013) of this issue.

ACA §9007 requires tax-exempt hospitals to establish financial assistance policies (FAPs) that specify eligibility criteria and indicate whether available assistance includes free or discounted care. FAPs must also set forth the basis for calculating patient charges and the method for applying for financial assistance. The 2012 NPRM further specifies that FAP-eligible patients may not be charged more than the amounts generally billed to patients with insurance covering such care (§1.501(r)-4 (b)(2)(i)(C)). It also proposes,

among other things, that a nonprofit hospital must make “reasonable efforts” to determine the patient’s FAP eligibility before it may sell patient debt to a third party, report adverse information to a credit reporting agency, or take any action requiring legal or judicial process considered to be an “extraordinary collection action,” listed in proposed rule §1.501(r)-(6).

All of the above provisions are designed to protect FAP-eligible patients. However neither the ACA nor the 2012 NPRM establish criteria for FAP eligibility. States wishing to align with federal requirements similarly can decline to establish criteria for FAP eligibility. Those states, thereby, will leave criteria to be established by individual hospitals or state or local hospital associations. If eligibility for financial assistance is determined by individual nonprofit hospitals, thereby maximizing hospital autonomy and flexibility, eligibility criteria may vary from one facility to another. Thus, a person’s financial obli-

gation may vary based on the site of their treatment. If hospital associations determine FAP eligibility, hospital compliance is likely to be voluntary and thus may not be followed by all hospitals.

If policymakers seek to establish or enforce uniform, statewide financial eligibility standards, legislative or regulatory action is generally needed. Many states already have such provisions in place: The ACA standards and those proposed by the 2012 NPRM overlay a patchwork of existing state regulatory schemes. A small number of states, including California, Maine, Maryland, New Hampshire, Oklahoma, Rhode Island, Texas, Utah, and Washington, already prescribe some form of statewide income eligibility standards in connection with paying for hospital care.

Minnesota has followed a non-legislative approach to offering financial protections to hospital patients. Although not required by law, all of the state's nonprofit hospitals have executed legally binding agreements with the Minnesota Attorney General (2012 Agreements). Those Agreements do not directly establish statewide eligibility standards for financial assistance. However, nonprofit hospitals must report the total dollar amount and the number of service con-

tacts between a patient and a provider in three categories: 1) patients with family income at or below 275 percent of the federal poverty level (FPL); 2) patients with family income above 275 percent of the FPL; and 3) patients for whom the facility, with reasonable effort, has been unable to determine family income when reporting charity care as part of required annual community benefit reports (Minn. R. 4650.0115.3). In addition, the 2012 Agreements:

- Limit hospital charges for services not covered by insurance. With respect to patients whose annual incomes are less than \$125,000, nonprofit hospitals may not charge more than the amount of reimbursement the hospital has received for the same service from the hospital's largest nongovernment payer during the previous year (2012 Agreements, ¶32).
- Specify circumstances in which the nonprofit hospitals may authorize credit collection entities to take legal action to collect medical debt (2012 Agreements, ¶1).
- List specific circumstances under which the nonprofit hospitals can pursue garnishment of patients' wages or bank accounts (2012 Agreements, ¶¶9 - 13).

Conclusion

The Hospital Community Benefit State Law Profiles identify state-level statutes, regulations, and occasionally the actions of executive agencies pertaining to state community benefit and reporting requirements, minimum community benefit thresholds, community health needs assessment, implementation plans, financial assistance, and other patient financial protections.

Taken together, the detailed categorization of state laws and regulations in the first companion brief to the Profiles and the analysis of selected policy issues for state decision makers in this

brief provide a context for considering each state's policies compared to federal community benefit benchmarks and the community benefit requirements of other states.

States are not required to defer to federal tax exemption standards, and they may choose to establish their own requirements for nonprofit hospital property, income, and sales tax exemption. The information in this issue brief has focused primarily on instances in which state and federal requirements both coexist and differ from one another.

As state policymakers assess and respond to the evolving federal landscape defined by ACA implementation and IRS rule making, they may wish to take each aspect of community benefit regulation into account.

Community Benefit Requirement. States vary widely regarding the existence of state-level requirements and the scope and nature of the benefits nonprofit hospitals are required to provide. Key stakeholder involvement may be critical to the development and ultimate acceptance of state-level requirements.

Mandatory Community Benefit Thresholds. A small number of states have adopted such thresholds. However, the IRS and 45 states have not adopted mandatory thresholds, and an evidence base supporting the effectiveness of such thresholds has not been established.

Community Benefit Reporting. Although carefully crafted, state-level reporting requirements can be used to advance state goals and priorities, state policymakers will want to consider the ensuing burden that may be experienced by both nonprofit hospitals and state officials.

Community Health Needs Assessment. The CHNA process should be open and inclusive, as well as administratively manageable, if the goal of identifying significant community health needs is to be efficiently and effectively accomplished.

Implementation Strategy/Community Benefit Plan. An implementation strategy, the written document setting forth a nonprofit hospital's plan to address needs identified by the CHNA, is a singularly important document. A plan to evaluate the impact of community benefit activities is a key aspect of that document.

Patient Financial Protections. A number of states offer a variety of financial protections to

patients of nonprofit hospitals. Policymakers can choose to specify eligibility criteria for these financial protections at the state level using legislative, regulatory, or, possibly, executive authority.

Legislators and decision makers in each state may wish to assess whether federal community benefit standards and patient financial protections are sufficient to satisfy state expectations of nonprofit hospitals, advance state policy goals, and address the needs of communities. Answers will depend on considerations unique to each state.

After thoughtfully considering the implications of available options, some states may choose to defer making any changes in law or policy until federal community benefit requirements, as defined by ACA directives and IRS rule making, are fully implemented and have been in place long enough to permit meaningful assessment of the combined effects of federal and existing state standards. The amount of time this will require is unclear.

The role of nonprofit hospitals in a post-ACA environment will be affected by significant changes in other evolving aspects of the health care system, including, but not limited to, changes in health care delivery and payment systems and the current trend toward industry consolidation. In conjunction with this altered landscape, many nonprofit hospitals can be expected to experience significant reimbursement differences as patient populations shift from being uninsured to being insured by public programs. All of these factors, taken together, are likely to affect nonprofit hospital community benefit opportunities and obligations; they should be taken into consideration as states reassess their community benefit regulatory frameworks and evaluate options for the future.

The information in this brief is provided for informational purposes only and is not intended as legal advice.

The Hilltop Institute does not enter into attorney-client relationships.

Endnotes

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² The Patient Protection and Affordable Care Act, P.L. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, P. L. 111-152 (2010). These consolidated Acts are referred to herein as the Affordable Care Act (ACA).

³ The IRS' 2013-2014 Priority Guidance Plan specifies its intent to work on final regulations for the additional requirements for charitable hospitals pursuant to ACA §9007 during the period ending June 30, 2014.

⁴ CA, DE, FL, IL, IN, ME, MD, MA, MS, MT, NV, NH, NM, NY, OH, PA, RI, SC, TX, UT, VA, WA, WV

⁵ For example, Florida law requires that nonprofit hospitals provide charity care and participate in the state's Medicaid program (Fla. Stat. §617.2002).

⁶ The California community benefit statutes cite improvement of community health status as one of their goals (Cal. Health & Safety Code §127345(c)).

⁷ Kansas uniquely ties its hospital debt collection limitations to how a patient's medical condition affects his or her ability to work (Kan. Stat. Ann. §60-231-(c)).

⁸ Community building activities address the root causes of poor health in areas such as education, employment, income, housing, community design, family and social support, community safety, and the physical environment (HHS, 2013; Institute of Medicine, 2011). At the federal level, community-building activities are reported separately in Part II of Schedule H, rather than in Part I, where community benefit activities are reported. However, since 2011, the IRS' Schedule H instructions have specified that, "some community building activities may also meet the definition of community benefit" and thus be reported as community health improvement activities (IRS, 2013b). For a full discussion of community building and related Schedule H reporting issues see Somerville et al., 2012.

⁹ See Minnesota's Profile.

¹⁰ For example, after considering all of the "facts and circumstances" the IRS decided that a nonprofit hospital that lacked an emergency department was nevertheless eligible for federal tax exemption, even though operation of a full-time emergency room was generally considered strong evidence that a hospital was operating to benefit the community. (Rev. Rul. 83-157, 1983-2 C.B. 94).

¹¹ The Nevada statute applies to nonprofit and for-profit hospitals that have at least 100 beds and are located in a county that has at least two licensed hospitals (Nev. Rev. Stat. §439B.320).

¹² The 2010 decision of the Illinois Supreme Court in *Provena Covenant Medical Center v. Department of Revenue* (Provena) (236 Ill2d. 368; 925 NE2d 1131) ignited a national discussion about community benefit policy. The lawsuit challenged Provena's tax exemption on several grounds, including the alleged inadequacy of the amount of charity care provided by the nonprofit hospital. The Provena court decided that certain parcels of the hospital-owned property were taxable on other grounds, but left unclear the issue of what constituted an adequate level of community benefit investment.

¹³ The Pennsylvania minimum community benefit statute is unique because nonprofit hospitals must first establish that they are "purely public charities" within the meaning of the state constitution, prior to satisfying the state's statutory minimum community benefit thresholds (Mesivtah Eitz Chaim of Bobov, Inc. v. Pike Co. Bd. of Assessment Appeals, 44 A.3d 3 (2012, Pa. S.Ct); *Hospital Utilization Project v. Commonwealth*, (HUP), 507 Pa.1 (1985, Pa. S.Ct).

¹⁴ This is consistent with an earlier study of Maryland nonprofit hospitals, which found that community benefit spending amounted to 7.4 percent of expenses in 2007 (Gray & Schlesinger, 2009).

¹⁵ As described above, those categories are: financial assistance (free and discounted care); unreimbursed costs of Medicaid and other means-tested government programs; community health improvement services and community benefit operations; health professions education; subsidized health services; research; and cash and-in-kind contributions for community benefit (2012 Schedule H).

¹⁶ CA, CT, GA, ID, IL, IN, MD, ME, MN, MS, MT, NH, NV, NY, NM, NC, OR, PA, RI, SC, TN, TX, UT, VT, VA, WA, WV, WI.

¹⁷ GA, ME, NM, OR, SC, VA, WA, WI.

¹⁸ Although technically not community benefit requirements because they do not reflect unreimbursed costs, Maryland requires that hospitals provide this information in their community benefit reports.

¹⁹ The NPRM also requires nonprofit hospitals to take into account, “Written comments received on the hospital facility’s most recently conducted CHNA and most recently adopted implementation strategy” (§1.501(r)-3(b)(5)(iii)).

²⁰ CA, ID, IL, IN, MD, NH, NY, RI, TX, VT, WA

²¹ Maryland nonprofit hospitals *must* consider the most recent community needs assessments developed by their state or local health department. (MD Code Ann. Health-Gen., §19-303(b).

²² ID, IL, IN, NY, RI, VT, WA

²³ Washington State requires nonprofit hospitals to “consult” with community based organizations, stakeholders and with local public health jurisdictions in connection with developing *implementation strategies*, not community health needs assessments. Wash. Rev. Code §70.41.470.

²⁴ The Texas Department of State Health Services has eleven public health regions responsible for delivering comprehensive public health services. Each Texas county is assigned to one of the regions. http://www.dshs.state.tx.us/chs/info/info_txco.shtm

²⁵ Texas has both local health departments and public health districts. <http://www.dshs.state.tx.us/regions/lhds.shtm>

²⁶ CA, IL, IN, MD, NH, NY, RI, TX, VT, WA

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About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a non-partisan health research organization dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels. Hilltop is committed to addressing complex issues through informed, objective, and innovative research and analysis. To learn more about The Hilltop Institute, please visit www.hilltopinstitute.org.

Hilltop's Hospital Community Benefit Program is the central resource created specifically for state and local policymakers who seek to ensure that tax-exempt hospital community benefit activities are responsive to pressing community health needs. The program provides tools to state and local health departments, hospital regulators, legislators, revenue collection and budgeting agencies, hospitals, and community-based organizations to use as these stakeholders develop approaches that will best suit their communities and work toward a more accessible, coordinated, and effective community health system. The program is funded for three years through the generous sponsorship of the Robert Wood Johnson Foundation (www.rwjf.org) and the Kresge Foundation (www.kresge.org).



The Hilltop Institute

analysis to advance the health of vulnerable populations

University of Maryland, Baltimore County
Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, MD 21250

Phone: (410) 455-6854 ~ Fax: (410) 455-1594

www.hilltopinstitute.org